SOUTHWESTERN

MEDICINE

October, 1949 Vol. 30 No. 10

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Southwestern MEDICINE

OFFICIAL JOURNAL OF THE SOUTHWESTERN MEDICAL ASSOCIATION AND THE EL PASO COUNTY MEDICAL SOCIETY

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October, 1949

ATTEND THE SOUTHWESTERN MEDICAL ASSOCIATION CONFERENCE IN ALBUQUERQUE NOV. 9-12

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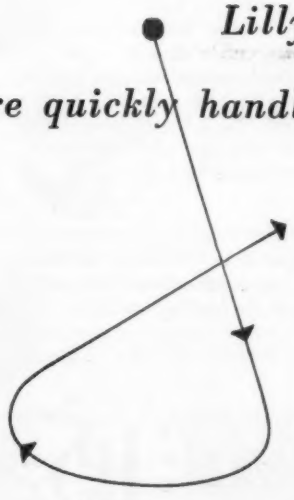

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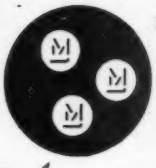

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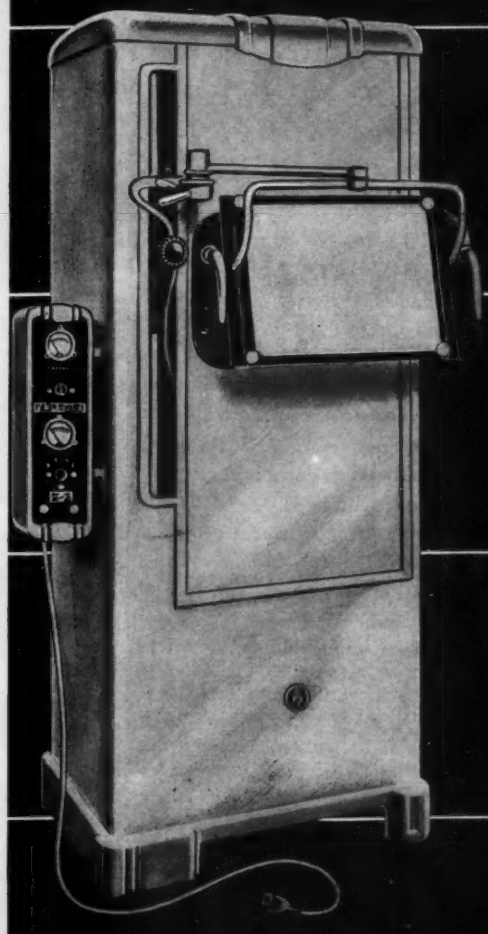

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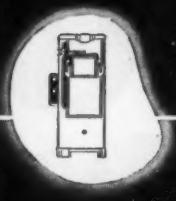

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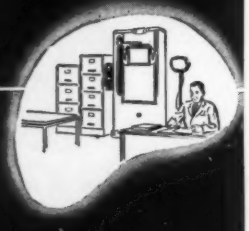

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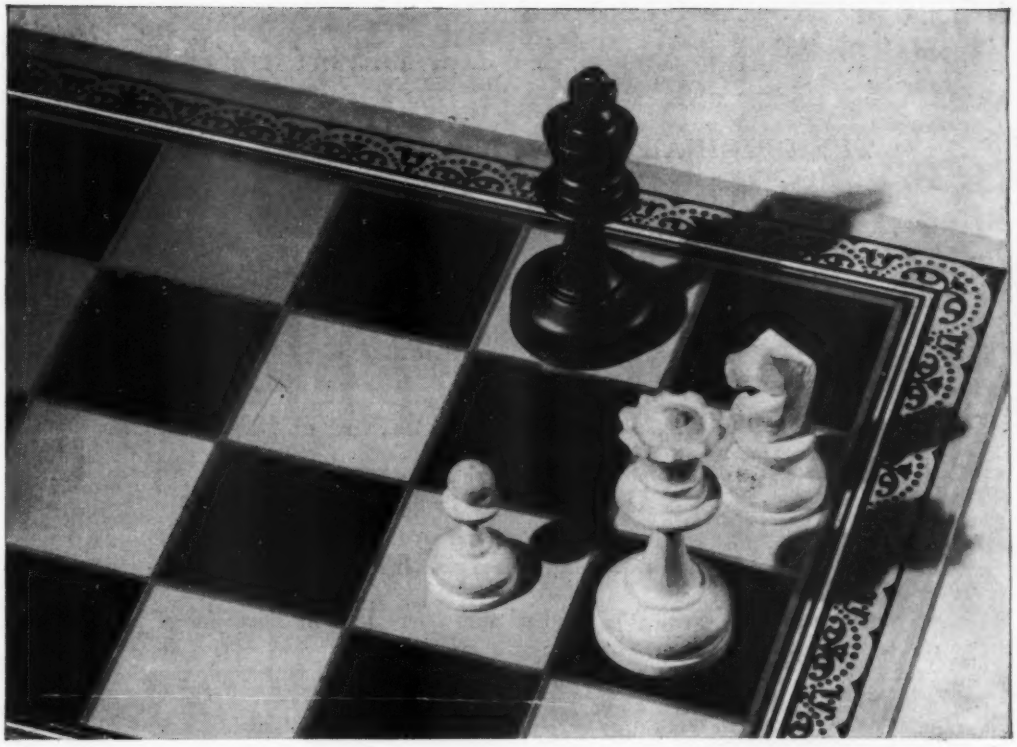

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SOUTHWESTERN MEDICAL ASSOCIATION CONFERENCE

The joint meeting of the Southwestern Medical Association, and the New Mexico Division of the American Cancer Society, to be held in Albuquerque, New Mexico, Nov. 9th, 10th, 11th, and 12th, offers unlimited possibilities as a post-graduate "refresher" course. The committee has been painstaking in its efforts to select outstanding essayists, and has succeeded in formulating a balanced program, from which each individual physician can derive definite and concrete benefits.

Scientific medical thought progresses so rapidly today that it is exceedingly difficult for the busy clinician to keep abreast of the fast-flowing tide. Recently at the dedication of Farnsworth Surgical Building in Boston, Mass., the distinguished sociologist, Chester I. Barnard, speaking concerning medical education, said, in part:

"Another lesson involved, and one not peculiar to the medical field but which applies to every professional field, including management of business, is that the education of competent professional people can never cease. Law schools do not turn out lawyers, engineering schools do not turn out engineers, and theological schools do not turn out theologists. Nor do medical schools turn out doctors. They turn out people trained to rapidly acquire from experience the best way to handle problems with which they are concerned, and trained to also understand the scientific language which they have to use.

"Whatever content of knowledge is involved in formal training is important and not misleading so long as there is not much damage, or only a very slow change, in the content of that knowledge; but when we are confronted, as we are today, with a constantly changing scientific structure and an evolution of new techniques so rapid that one of our major problems is how to keep up with developments, then the need for further formal education of experienced practitioners becomes paramount."

The integrity and the wisdom of Mr. Barnard's observations are unquestioned. However, formal education, even though desirable, is difficult to obtain, but the fa-

cilities offered in Albuquerque at the coming conference are within the reach of each and every practitioner in the surrounding area. Let's make this the largest and best meeting of the Southwestern Medical Association.

The committee on arrangements present the following speakers:

DONALD M. PILLSBURY, M.D., born 1902; graduated Nebraska 1926; Professor of Dermatology and Syphilology, School of Medicine, University of Pennsylvania; Dermatologist to the Hospital of the University of Pennsylvania, the Children's Hospital of Philadelphia, the Bryn Mawr Hospital; Member of the Syphilis Study Section, of the National Institutes of Health; Member-at-Large of the Section on Clinical Investigations of the Committee on Growth of the National Research Council.

HERBERT F. TRAUT, M.D., born 1894; graduated Johns Hopkins 1923; Professor and Chairman of Department of Obstetrics and Gynecology, University of California Medical School; Consulting Obstretician and Gynecologist, San Francisco Hospital; Visiting Gynecologist, Laguna Honda Home, San Francisco; Consulting Obstetrician and Gynecologist, Langley Porter Clinic, San Francisco. He will speak on "The Use of the Vaginal Smear in General Gynecological Diagnosis" and "Bleeding in the Third Stage of Labor."

ELMER BELT, M.D., born 1893; graduated University of California 1920; Attending Urologist: Hospital of the Good Samaritan, Los Angeles; Hollywood Presbyterian Hospital, Los Angeles; Cedars of Lebanon Hospital, Los Angeles; St. John's Hospital, Santa Monica; St. Francis' Hospital, Lynwood; Union Pacific Railway, Los Angeles. Consultant in Urology: Orange County Hospital; Ventura County Hospital; Children's Hospital, Los Angeles; Orthopaedic Hospital, Los Angeles; Physicians and Surgeons Hospital, Glendale. He will talk on "Radical Removal of the Bladder with Transplantation of the Ureters" and "Office Urology."

KENNETH D. A. ALLEN, M.D., born 1889; graduated University of Pennsylvania 1916; Associate Professor of Radiology University of Colorado; President of the Rocky Mountain Radiological Society; Formerly Senior Consultant in Radiology U. S. Army, European Theater, World War II. He will talk on "Practical Considerations of Carcinoma of Cervix Uteri' 'and "'Scout' X-ray Study of the Abdomen. Its Value to a General Practitioner."

WILLIAM BOYD, M.D., born 1885; graduated University of Edinburgh, 1908; Professor of Pathology and Bacteriology, University of Toronto; Pathologist, Toronto General Hospital, Toronto, Ontario; World renowned author. He will speak on "The Spread of Tumors" and "Glomerulonephritis."

OTTO C. BRANTIGAN, M.D., born 1904; graduated Northwestern 1934; Professor of Clinical Surgery and Professor of Surgical Anatomy, University of Maryland School of Medicine; Chief of Thoracic Surgery, University Hospital, Baltimore, Maryland; Surgeon-in-Chief, Baltimore City Hospitals. He will speak on "Carcinoma of the Lung" and "The Surgical Treatment of Peptic Ulcers."

EVANS W. PERNOKIS, M.D., born 1898; graduated Harvard Medical School 1923; Associate Professor of Medicine, University of Illinois Medical School; Attending Physician of Presbyterian Hospital, Chicago; Attending Physician of Cook County Hospital, Chicago. He will speak on "Leukemia" and "The Treatment of the Anemias."

E. T. BELL, M.D., born 1880; graduated University of Missouri 1903; Professor and Head of the Department of Pathology, University of Minnesota 1920 to 1949, retired June 1949; Author of a Textbook of Pathology, now in its sixth edition; Author of a monograph of Renal Diseases; Many papers on renal diseases published; Research on diabetes now in progress. He will talk on "Experimental Production of Cancer" and "Pathology of Diabetes Mellitus."

HERBERT WILLY MEYER, M.D., born 1896; graduated Columbia; Professor of Clinical Surgery, Post-Graduate Medical School, New York University, Bellevue Medical Center; Visiting Surgeon, Fourth Surgical Division, Bellevue Hospital, New York; Associate Attending Surgeon, Lenox Hill Hospital, New York. He will talk on "Cancer of the Breast," "Diaphragmatic Hernia", and "Perforations of the G. I. Tract."

WILLIAM A. H. RETTBERG, M.D., born 1907; graduated University of Colorado 1935; Assistant Professor of Medicine, University of Colorado School of Medicine; Director of Hematology, University of Colorado Medical Center. He will speak on "Indications for Antibiotics."

ALLAN M. BUTLER, M.D., born 1894; graduated Harvard, 1926; Professor of Pediatrics, Harvard Medical School, Boston, Mass.; Chairman, Council, American Pediatric Society; Vice-Chairman, Physicians Forum; Vice-Chairman, Committee for the Improvement of Medical Care, Inc.; Member of Editorial Board, **Pediatrics, Quarterly Views of Pediatrics, Advances in Pediatrics, Annual Review of Medicine.** He will talk on "Parenteral Fluid Therapy" and "Diabetes."

Many Firms To Exhibit At S.W.M.A. Conference

An unusually fine and varied group of pharmaceutical, surgical and commercial displays are already assured for the Conference of the Southwestern Medical Association which will be held in Albuquerque November 9-12.

No less than 20 firms have reserved exhibit space in the Hilton Hotel, headquarters for the Conference, by August 20, Dr. Bennett F. Roberts, chairman of exhibits, has announced.

Many more are expected to make reservations before the Conference begins, Dr. Roberts said.

The 20 companies, which have already scheduled exhibits, are:

G. W. Carnrick Co., Newark, New Jersey.
E. R .Squibb & Sons, Long Island City, N. Y.
C. B. Fleet Co., Lynchburg, Virginia.
G. D. Searle & Co., Chicago, Illinois.
Ciba Pharmaceutical Products, Inc., Summit, New Jersey.
Mead Johnson & Co., Evansville, Indiana.
Mission Pharmacal Company, San Antonio, Texas.
W. B. Saunders Co., Philadelphia, Pa.
Lanteen Medical Laboratories, Inc., Chicago, Ill.
A. H. Robbins Co., Richmond, Virginia.
Eli Lilly & Co., Indianapolis, Indiana.
Schering Corporation, Bloomfield, New Jersey.
Bilhuber-Knoll Corporation, Orange, New Jersey.
Don Baxter, Inc., Glendale, Calif.
A. S. Aloe Co., St. Louis, Missouri.
Maico Hearing Aid, Phoenix, Arizona.
Blair Surgical Supply Co., Inc., Tucson, Arizona.
Sandoz Chemical Works, Inc., San Francisco, California.
General Electric X-Ray Corporation, Dallas, Texas.
The J. Durbin Surgical Supply Co., Denver, Colo.

"KTENOLOGY," THE SCIENCE OF KILLING

Dr. Leo Alexander, formerly consultant to the Secretary of War, on duty with the Office of the Chief Council for War Crimes, Nuremberg, United States Zone of Germany, during the years 1946 and 1947, proposed the term "ktenology" which in itself means, "the science of killing." Dr. Alexander on his tour of duty was able to obtain first-hand information, and he has written several articles which have disclosed the horrible and vicious practices of certain of the practitioners of medicine in Nazi Germany during World War II.

On first thought one may wonder what advantage an article on such a morbid subject could possibly have in advancing medical knowledge or ethics. However, when it is considered that the rationalization of these mass killings was accomplished through the utilitarian philosophy of Hegel, which has for its corrollary, euthanasia, it well may follow that the mass extermination of the chronically ill in the interest of saving "useless" expenses to the community will be the guiding philosophy of any dictatorship.

How the science of killing worked out in Germany has been admirably set forth by Dr. Alexander in a paper, entitled "Medical Science Under Dictatorship." (1) Apparently, like every other program instituted by psychopathic dictators, it became so enormous that it got completely out of hand. What actually happened was that mass extermination became an extremely adequate means of ridding the politicians of people whose philosophy was not in accord with theirs. Hence, large numbers of people were marked for death for political and racial reasons.

This ideology degenerated to the point that a neuropathologist, Dr. Hallervorden, made the following statement regarding the selection of patients for extermination:

"These were selected from various wards of the institutions according to an excessively simple and quick method. Most institutions did not have enough physicians, and what physicians there were, were either too busy or did not care; and they delegated the selection to the nurses and attendants."

"Whoever looked sick or was otherwise a problem was put on a list and was transported to the killing center. The worst thing about this business was that it produced a certain brutalization of the nursing personnel. They got to simply picking out those whom they did not like; and the doctors had so many patients that they did not even know them, and put their names on the list."

LIVE DISSECTION

As one reads of such procedures as live dissection, heteroplastic transplantation, in which whole limbs were amputated, wrapped in sterile, moist dressings, and sent by automobile to hospitals where the procedure was tried with absolutely negative results; and the prisoners deprived of the limb usually exterminated by lethal injection, the question of the motivation of the men lending themselves to these horrible experiments arises. Apparently it was not ferocity; it was fear and cowardice.

For example, Dr. Sigmund Rascher, the noted vivisectionist, was suspected of being a communist, and committed his dastardly crimes in order to gain full-fledged acceptance by the Nazi party.

Professor Gebhardt performed these experiments to clear himself of the suspicion that he had contributed to the death of General Reinhard Heydrich by failing to treat the General's wound infection with sulfonomides. The General died from gas bacillus infection; and Himmler told Dr. Gebhardt that the only way that it could be proven that Heydrich's death was fate-determined was to carry out experiments on prisoners that would prove or disprove that people died from gas bacillus infections, whether or not they were treated with sulfonomides.

HEGELIAN PRINCIPLE

In the United States today, with the advent of ever-increasing knowledge in the science of medicine, the physician is more and more turning towards rehabilitation of the patient as the goal of his endeavors; and unconsciously there creeps in the Hegelian principle, "what is useful is good." When a patient becomes chronically ill; and there is literally no chance of rehabilitation of this patient, sad but true, the physician's interest is apt to wane.

Hospitals do not wish to accept the burden for cases which are relatively incurable. Institutions for the care of incurable cases are few and far between; and many of those that are available are not, let us say, first-class institutions for the treatment of the chronically ill patient.

CONVALESCENT HOMES

The American medical profession will never stoop to the level that the followers of Hitler did, but the profession must recognize that a certain percentage of patients that are chronically ill cannot be rehabilitated, and that someone must take care of these patients. These patients should not be placed in convalescent homes, administered by laymen who have simply a pecuniary interest, and not the interest of the alleviation of pain.

We must recognize the fact that these patients are human beings, and that their suffering and pain must be alleviated by analgesics and pain-relieving operations, which have now been developed to the point to where there can be essentially no rationalization for euthanasia. We must return to the older premises in which the physician's function was to give hope to the patient. We must give this hope in spite of what we may regard as hopeless. It is only through an attitude such as this that occasionally patients whose recovery has been entirely doubtful have fooled the best prognosticators.

NO CERTAINTY

The medical profession has not, and in all probability, will not arrive at a point of perfection at which we can accept an attitude of absolute certainty as regards prognosis. In view of the fact we must by necessity remain simply individuals attempting to alleviate suffering by scientific means and not become overwhelmed by our sense of importance so that we make a vain attempt to emulate the Great Healer.

1. "Medical Science Under Dictatorship", Leo Alexander, M.D., Boston, **New England Journal of Medicine**—Vol. 241, July 14, 1949, No. 2., P-39.

Treatment Of Infective Asthma: Penicillin In Beeswax And Oil

"Thirty-nine cases of intrinsic asthma treated with 600,000 units of penicillin in wax and oil daily, followed by similar booster doses every five to seven days, are reported. Thirty-one were improved.

"It is concluded that **any** case of infective asthma deserves a trial with penicillin in wax and oil, and the majority will benefit materially."—Gay, L. N., and Marriott, H. J. L., **Tr. & Stud. Coll. Physicians, Philadelphia** 15:91, 1947.

"Grotesque, Medieval, And A Shame"

The United Mine Workers have a clause in their contract with the coal industry which states that the miners are required to work only when they are "willing and able." This in itself is a unique situation. Apparently no consideration has been given business or the innocent public who might need coal.

John L. Lewis is a verbose individual, and he makes a specialty of headline phrases, and his latest is "menacing instability". Our old friend, John, promulgates the theory that heavy supply of coal on hand threatens the national economy, but what it really threatens is the economy of the United Mine Workers.

LEWIS VERBOSE

Mr. Lewis' verbosity manifests itself as regards business and professional men in a United Press dispatch in which the U.M.W. Journal comments as follows:

"The greed of gallivanting physicians is giving socialized medicine a big lift. It used to be the tired businessman who led the parade of those who flocked to the girl shows, tripped the light fantastic, and drank an overflow of liquor in the role of good-time Charlie. But physicians today are giving the businessman a run for first honors."

Now how do you suppose good old John found out that the doctors were ruining their eyesight? Surely the poor, downtrodden miners, who can only work when they are willing and able, would not be able to afford a ringside table at these expensive night clubs. Could it have been good-time John himself? It might be suspected that perhaps he could afford it, although he has not paid, as yet, the twenty thousand dollars out of the $1,400,000 which he and his cohorts caused the miners to be fined.

SOCIALIZED MEDICINE

Let us stop for a moment and consider why Mr. Lewis favors socialized medicine. Note that he doesn't call it compulsory health insurance; he labels it correctly. He understands panel medicine. He has had a first-hand opportunity to see it work. The miners pay for their medical care through wage deductions, two or three dollars a month. For another three dollars a month, each miner and his family get free hospital coverage with only venereal disease and obstetrics excepted.

Could it be that this type of medicine has not been entirely successful? If it had been a success, why should Mr. Lewis and his miners support socialized medicine? It could be simply for political reasons, because Mr. Lewis and his miners have defied the government and the public time and time again, and apparently will continue to do so; and the government will continue to do nothing about it.

GOVERNMMENT INTERFERENCE

One does not have to rationalize greatly to see that there must be something the matter with Mr. Lewis' panel medicine. Or Mr. Lewis is perfectly willing that the government interfere with industry so long as the government doesn't interfere with the United Mine Workers; and when the Southern Coal Producers' Association asked that the miners give up their one-half hour paid lunch periods and add to the working time at the coal face, and that the clause be eliminated requiring the miners to work only when "willing and able," Mr. Lewis became highly indignant and put on his hat and went home, and left Mr. John Owens, the Union Secretary, to fume at Mr. Moody, and to assert that such demands by industry were "grotesque, medieval, and a shame."

Gallup Indian Clinic Reopened

The Navajo Medical Clinic, which has been closed for the past year, has been reopened for the treatment of the Navajo Indians in and around Gallup. Dr. H. T. Watson of Gallup is medical director of the Clinic.

Dr. Watson has been in McKinley County for the past 31 years. He has been in private practice in Gallup 26 years and is well known among the members of the profession throughout New Mexico. He is closing his office for the private practice of medicine and will devote all his time to his new duties.

Dr. H. W. Kassell, the medical director for the Navajo Service, has announced that a new and up-to-date building will be erected in the near future. In this new building besides the Navajo Clinic and dispensary will be the headquarters for the Indian Field Health Unit which will consist of the medical director for the clinic, a dentist, five field nurses and a sanitarian.

The Navajo population and the people of McKinley County are happy to see the clinic revived under the direction of such an able man as Dr. Watson, this being the first step to provide the Navajo Indians in McKinley ounty with improved facilities for better and up-to-date medical care.

By VINCENT ACCARDI, M.D., Gallup, N. M.

Hospital Records Or "Fly Tracks"

Detroit Medical News (October, 1947) reported that at a clinical pathological conference in one of their Detroit hospitals, a case history was presented together with the following explanation:

". . . We were unable to read most of the hospital chart. . . . We called in various experts to help us decipher the record. As is usual with experts, they did not agree. The Army cryptologists . . . held the view that the chart was written in Japanese. . . . The archeologists of Columbia University stated flatly that the document constituted a remarkable example of early Runic poetry. . . . The Leland Stanford faculty was equally certain that the document was a case history from a Babylonian insane asylum. The Crime Laboratory of Northwestern University . . . asserted that the characters in question were the aimless wanderings of a young housefly not yet house-broken . . ."

All hospitals make much ado about completed records but some appear to be more concerned with the number of lines written than the legibility of the record. If all hospitals required typewritten records and provided personnel for that purpose, the difficulties of deciphering hieroglyphics would be obviated and the records would be more detailed and complete.

Effect Of Chloromycetin In Typhoid Fever

"A new antibiotic, Chloromycetin has been clinically tested in the treatment of typhoid fever . . . Serum levels of the drug after oral administration have been found to be comparable to those obtained by parenteral injection.

"Reports on . . . Chloromycetin in the treatment of human infections, up to the time of writing, have been confined to its use in epidemic typhus and in scrub typhus. In both of these rickettsial infections [it] has demonstrated marked therapeutic effectiveness." — Woodward, T. E., **et al., Ann. Int. Med.** 29:131, 1948.

New Otero County, N. M., Hospital

The Gerald Champion Memorial Hospital In Alamogordo.

The new Gerald Champion Memorial Hospital, one of the finest small, county hospitals in the United States, was opened with appropriate ceremonies late this summer, thus bringing to Otero County in southern New Mexico, the most modern and complete medical facilities.

The new hospital was dedicated July 31 and accepted its first patients August 2.

It was constructed at a total cost of $224,000. The building itself, was erected by Ponsford Brothers of El Paso for $154,000. Nurses quarters cost another $18,000. The remainder of the sum was used for purchase of scientific and medical equipment and supplies.

The money for construction of the new hospital came from three sources. Residents of Otero County contributed $104,000 during a vigorous subscription campaign. Then voters by a heavy margin approved a $50,000 bond issue for the hospital; and lastly the federal government contributed $70,000.

Mrs. Grace G. Powe is both superintendent of the hospital and superintendent of nurses. Only graduate registered nurses serve in the hospital.

Facilities include 26 beds, 14 of them in private rooms and 12 in wards.

The hospital also includes an operating room and obstetrical and out-patient wards.

Equipment includes x-ray and laboratories with a trained and registered technician, basal metabolism apparatus, electrocardiograph and diathermy machine equipment.

Opening of the Gerald Champion Memorial Hospital in Alamogordo represents the culmination of more than three years of hard work and diligent planning by public minded citizens of Alamogordo. Time, money and various other contributions were made by a very large proportion of the residents of the county.

The idea for construction of the hospital first took shape at a meeting of Alamogordo Chamber of Commerce in April, 1946. At that time a goal of $100,000 for construction of the hospital was established, and Gerald Champion of Tularosa, an outstanding civic leader, was chosen to head the campaign.

The first hospital board was elected in June, 1947, with the following members: Gerald Champion, chairman; Mose Cauthen, vice-chairman; L. A. Hendrix, secretary; M. R. Prestridge, Chris Gallegos, Father Francis, Dan King, Mrs. J. F. Mahill, and P. B. Hendricks.

The tragic death of Gerald Champion in a plane crash in February, 1948, made Mose Cauthen chairman. C. E. Moore was appointed to fill the vacancy, and John Larkin succeeded to the post vacated by Father Francis when he moved from Tularosa.

The board in February 1948 voted to name the hospital the Gerald Champion Memorial Hospital in memory of Mr. Champion.

Site of the hospital was deeded by the Hospital Association to Otero County in November 1948.

Digitoxin Intoxication

"Digitoxin has practically replaced digitalis USP (digitalis leaf), but the dangerous aspects of its administration have been disregarded and digitoxin intoxication has become frequent. . . .

"The administration of digitoxin, like that of any other preparation of digitalis, because of the variability in absorption, excretion and therapeutic effect, is an individual experiment.

"The dosage of 1.2 mg. as a single digitalizing dose and of 0.2 mg. for maintenance has often been applied indiscriminately to patients regardless of weight, without proper surveillance of the patient and without awareness of the dangers involved in using the drug. It must be remembered that the daily maintenance dose of digitoxin varies from 0.05 to 0.02 mg."—Master, A. M., **J. A. M. A.**, 137:531, 1948.

Diagnosis And Treatment Of Subphrenic Abscess*

By E. VINCENT ASKEY, M.D., Los Angeles, Calif.

A surgeon usually has several degrees to put behind his name. Of late he has been accused of having two additional ones which, depending upon the use to which he puts them, may be harmful or of benefit to his patient. I refer to B.A.B. and B.S. Before antibiotics and before sulfonamides. Reliance on either medication as a cure-all, hoping to avoid surgery, may sound the death knell for a patient. The failure to use them as an adjuvant to surgery may be equally disastrous. In no other condition is this statement more applicable than in the treatment of subphrenic abscess.

DR. ASKEY

ASPECTS CLARIFIED

Ochsner and Graves, in 1931 and 1933, clarified many important aspects of the condition. I fear, however, that one important statement they made has been misread and misinterpreted, especially since the B.A.B. and B.S. degrees have been added to our names. They estimated that 70 per cent of subphrenic infections subsided spontaneously. Relying on this statement, antibiotics and sulfonamides have been used in frank abscess below the diaphragm, delaying surgery to the extreme detriment of the patient. Ochsner did not say that 70 per cent of subphrenic abscesses subside spontaneously. That is an extremely important point to remember. Unfortunately, very few, if any, of these abscesses will subside without adequate surgical drainage. Many men have called attention to the fact that once a subdiaphragmatic abscess has formed, it constitutes an overpowering menace to the patient's life until it is accurately diagnosed and adequately drained. I believe that the best that can be expected of chemotherapy in these cases, when used without surgery, is the putting off of the evil day of catastrophe that is practically inevitable. Used as an adjuvant to surgery, the story of course is that of a different colored horse.

SUBPHRENIC ABSCESS

Subphrenic abscess is an intriguing thing to a surgeon. It calls into play almost all the factors most involved in his professional life. The condition usually follows an harrowing experience of a difficult case that already has taxed the surgeon's resources as well as the family's. It may on the other hand suddenly arise to complicate a battle that was apparently won. Added to this is the extreme difficulty in arriving at the correct diagnosis, and then in deciding on the correct approach in the technique of the operation. As Maingot says, "The pathology of the condition is complicated by the intricacy and the multitudinous anatomical arrangements and connections of the subdiaphragmatic region. Diagnosis is difficult. This is in part due to the inaccessibility of the subphrenic region and partly to neglect to consider the possibility of subphrenic abscess in the individual case."

FOLLOWS LESION

Subphrenic abscess is primarily a localized suppurative accumulation that has followed some intra-abdominal lesion and infection.

Appendicitis is the most common cause but perforated ulcer, perforated gallbladder, perforated diverticulitis, or pelvic infection as well as many other conditions may initiate the train of sequence that eventuates in subphrenic abscess. It may follow gastrectomy or splenectomy.

From the year 1845, when Barlow first discovered the condition clinically, and after 1908, when Barnard made his diagnostic dictum, "Signs of pus somewhere, signs of pus nowhere else, signs of pus there," and until Ochsner proposed and perfected the technique of retroperitoneal subpleural drainage, the mortality was appalling. It still is a condition that we can learn about.

For the sake of orienting ourselves, a review of the anatomy at this time will not be amiss.

Martinet originally gave an accurate and detailed description of the subphrenic spaces.

I like personally the succinct and clear description of Philip Thorek in fixing in my mind the six subphrenic spaces.

THREE SUPRAHEPATIC SPACES

The suprahepatic region is divided by the falciform ligament into right and left parts. Space One is situated to the right of the falciform ligament, above the liver and anterior to the right lateral ligament. It is, therefore, called the right superior anterior space. Space Two is located at the right of the falciform ligament, above the liver and behind the right lateral ligament. It is called the right superior posterior space. Spaces One and Two are separated from each other posteriorly by the bare area of the liver. Space Three is found to the left of the falciform ligament; and since the left lateral ligament passes posteriorly along the flattened left lobe of the liver, there is only one space on this side in contrast to the two on the right. It is called the left superiorspace.

THREE INFRAHEPATIC SPACES

The infrahepatic region is divided by the descending duodenum into right and left parts. For convenience we have numbered these spaces Four, Five and Six. Space Four is to the right of the duodenum, and below the liver. It is, therefore, called the right inferior space. This is the same as the hepatorenocolic pouch of Morison. Space Five is found to the left of the duodenum, and below the liver and in front of the stomach. It is called the left inferior anterior space. Space Six is located to the left of the duodenum below the liver and behind the stomach. It is called the left inferior posterior space or lesser peritoneal cavity.

We have now considered the easiest part of the problem. We know that there is such a thing as subphrenic abscess. We know the anatomy of the spaces. The difficult thing is to diagnose the condition when we are confronted with it.

Paradoxically, the most difficult part of the diagnosis should be the easiest. I believe the greatest mistake made in failure to diagnose subphrenic abscess early is the failure to think of it as a possibility. Once it is thought of; and the diagnostic aids, which we have at our disposal are used, we may expect reasonably a fair average of success.

In my opinion, the greatest aid in diagnosis is the X-ray. Given a case with fever, leucocytosis, pain and previous abdominal infection with the train of symptoms that makes us think of subphrenic abscess, the X-ray is our first resort. The fluoroscope is important in showing fixation or limitation of motion of the diaphragm. However, plates are equally important and may be definitive.

*—This article was presented before the International Post-Graduate Assembly in San Antonio.

Three positions should be used:

1. Anterior posterior with patient sitting up.
2. A lateral film with patient sitting up.
3. Anterior posterior with patient lying on side with the affected side up.

ARTIFICIAL PNEUMOPERITONEUM

If these are not definitive, artificial pneumoperitoneum should be introduced and the pictures as above described repeated. This has proved of great value. The procedure in the hands of an experienced peritoneoscopist is not difficult. I have been fortunate in having advice in this regard from Dr. Robert B. Hope of Los Angeles, a former associate of Dr. John Ruddock.

I was interested to see in an article by Dr. Leroy Santi that he agrees with me in the value of pneumoperitoneum and he is speaking as a roentgenologist. He says, "One way in which infection of the subphrenic space can be demonstrated is by the aid of artificial pneumoperitoneum. If it is the site of inflammation, the adherence of the diaphragm to the upper surface of the liver or spleen will prevent access of air to this region. In cases of basal exudate in the pleural cavity it is of great help to determine whether it is a simple pleural exudate or is associated with a pyogenic infection below the diaphragm."

This procedure is the one I wish to discuss today. The utilization of artificial pneumoperitoneum will give more definitive information than other procedures with less danger. This observation demands the consideration of aspiration as a diagnostic procedure in subphrenic abscess.

To aspirate or not to aspirate is a moot question, yet, although even those who advocate its use emphasize that it should be done only immediately before operation; so that, if pus is found, immediate incision and drainage may be carried out. There are two great dangers in aspiration. First, the great danger of pleural contamination with resultant infection and empyema. Second, the one I fear more, a negative finding on aspiration. A negative finding on aspiration, if done, should not be allowed to delay surgery, if it is otherwise indicated. If this statement be true, and I believe it is, then I see no benefit to the aspiration and there is considerable added risk.

As in all things, however, there is exception to this rule and I must answer the old question with the old answer. Do you never aspirate? Well, almost never. There is a place for aspiration and it is as follows:

Given a case with definite pleural effusion, which may be either concommitant with subphrenic abscess, or, is a basal pleural effusion, I believe aspiration of the pleural effusion is indicated. This in conjunction with artificial pneumoperitoneum is then often definitive and of great value. When the coordinated signs point strongly to the diagnosis, I believe that exploration may be done with less danger to the patient than will be risked by added delay. Unnecessary delay courts disaster.

OCHSNER APPROACH

Then how shall the operation be carried out?

Fortunately, as Bailey points out, the right subphrenic spaces are involved more than the left in ratio of about seven to one. In these right abscesses Ochsner extraperitoneal and subpleural approach is much to be preferred. If the posterior space be involved the resection of the twelfth rib and approach to the abscess can be accomplished rather readily. If the right anterior inferior space be involved usually it is glued to the anterior abdominal wall and is pointing with a relatively easy drainage being possible. If the right anterior superior space be involved the Ochsner approach again is the choice.

However, those abscesses of the left spaces are open to more discussion as to the procedure of choice.

Neuhof and Schlossman have called attention to the fact that since the stomach, spleen, and other structures constituting the lower boundaries of the left anterior superior space are more mobile, that there tends to be less elevation of the diaphragm. Usually, considerable displacement downward and medially of the stomach and colon may be found. They call attention to the added help that the administration of a gas forming medication, such as Seidlitz powder, may give in the X-ray examination by filling the stomach with air and allowing the abscess to be delineated through the bubble. A left sided abscess in the anterior superior space points either thoracically or abdominally. For the abdominal pointing the subpleural approach is satisfactory. For the thoracic pointing type Neuhof and Schlossman. believe a transpleural transdiaphragmatic approach is preferable. The diaphragm is sutured securely to the musculature of the thoracic incision and the free pleural space is shut off. The diaphragm is then traversed and drainage established.

The left posterior inferior space, or the lesser peritoneal cavity, may also be approached through the gastro-hepatic omentum as indicated by Thorek, but this involves transperitoneal contamination and its concommitant disadvantages.

Fortunately, I have not had experience with the left sided abscess.

SUMMARY

I would summarize then the importance of:

1. The continued realization that subphrenic abscess should not be treated exclusively by reliance on the antibiotics or the sulfonamides.
2. There are six definite subphrenic spaces that must be kept in mind.
3. X-ray examination by the three position method is imperative.
4. Pneumoperitoneum is a means of added refinement in diagnosis.
5. Drainage by the Ochsner method is preferable and adequate except possibly in the left sided thoracic pointing abscess in which the transpleural-transdiaphragmatic approach may be the choice.
6. The greatest single diagnostic aid in subphrenic abscess is the alertness of the surgeon in thinking of it as a possibility.

The Prevention And Treatment Of Motion Sickness

"During a period of 10 days, Dramamine [beta-dimethylaminoethyl benzohydryl ether 8-chlorotheophyllinate] was given to 389 cases of seasickness. Of this number, 372 were completely relieved of symptoms within 1 hour after the first dose of 100 mg. Seventeen cases derived only partial or no relief. A dose of 100 mg. prescribed every 5 hours and before retiring was adequate to control the most distressing symptoms. When the patient was unable to retain a capsule administered orally, he did retain and absorb the drug given rectally. The benefit derived by this method was as rapid and as complete as that derived by the oral method."—Gay, L. N., and Carliner, P. E., **Science** 109:-359 (Apr. 8), 1949.

Influence Of Southwestern Climate on Diseases of the Nose and Sinuses

By M. P. Spearman, M.D., F.A.C.S., El Paso, Texas

Speaking of the vagaries of the weather and climate, and slyly digging at man's inability to alter them, one famous writer [1] has said "probable Nor'-East to Sou'-West winds, varying to the southward and westward and eastward and points between; high and low barometer, sweeping about from place to place; probable areas of rain, snow, hail, and drought, succeeded or preceded by earthquakes with thunder and lightning."

Weather and climate are spoken of as being abstract things, annoying, interfering or pleasing as the case may be. Weather is a combination of temperature, light, moisture, air movement, barometric pressure. The prevailing sum of these variables make up a given climate. The action of these phenomena upon living and inanimate objects constitutes a gigantic, mysterious, never ending chemical process, so that it may be said that all things, as we know them, exist in a huge chemical retort, known to us as the world and its enveloping atmosphere. Logically, then, man is subjected to a number of pressures and interactions by the surging of climatic influences upon him. His climate modifies and shapes his food, his housing, his disposition to laze or to fight or invent, his physical and mental development in groups or as an individual, and his health. And, in a large sense, man's health is simply a measure of his ability to adjust himself to his environment and to the changing climatic factors that shape that environment. Therefore, it is fruitful for physicians to observe and study the influence upon man of his climate.

EFFECTS OF WEATHER

Easily observed and recorded in the books of geology and chemistry are the effects of the crackling frosts of a thousand dark winters upon the rock masses of the earth. Any amateur gardener knows that certain plants, beautiful and healthy in climates far from his, simply will not do in his part of the world. And he can cite fairly good ideas as to why this is so. More esoteric are the final reasons why one man may enjoy good health in a certain area, but be reduced to illness by living in another.

It has been known for a long time that it is good therapy to advise patients to change climates at times. Indeed, Mills, [2], in an exhaustive study of climate in relation to disease, says that "storminess or atmospheric turbulence with the accompanying sudden changes in temperature, pressure, humidity, etc., is now recognized as a major disturbing factor in certain regions of the earth where cyclonic storms prevail. These sudden changes in the atmosphere seriously disrupt tissue functioning in ways as yet little understood and seem closely related to the initiation of many types of acute infectious attacks. Storm changes certainly constitute a major health factor in regions where they are frequent and abrupt, but much more evidence must be accumulated before the physiology of their effects can be understood clearly. Physicians should realize that individuals differ greatly in their sensitiveness to storm changes. Some are utterly unfitted for existence in a stormy region and should be advised of the advantages of migration to a region of less turbulence."

Further, the same authority, after study of weather and storm data says:

"Cyclonic storm changes seem to be a potent factor in the initiation of the infections. Migration should therefore be to a non-stormy and warm region. In North America that would mean the Southwest within 200 miles of the Mexican border from El Paso to the Pacific coast."

Petersen [3] has noted precipitation of symptoms and change in the clinical course of various ocular diseases with a change in meteorologic environment.

EL PASO CLIMATE

In the deep Southwest, in and near El Paso, lies a vast area of semi-aridity, at an altitude of 2000 to 4000 feet. Rainfall is about nine inches annually. The sun shines more than 80 per cent of possible hours throughout the year. During the winter months the sun beats down 70 per cent to 80 per cent of all possible hours. Thus, there is a combination of moderate altitude above sea level, dry atmosphere and bright sunshine throughout the year, together with freedom from cyclonic storms.

As might be expected, many visitors from the midwest and the North take up residence in this area during the winter months, thus to escape the icy blasts and deep snows storming into their native areas. Many patients are sent to the Southwest by their physicians, espcially during the winter season. Not all benefit from the dry weather, and one observer, Egbert [4], has remarked upon the dryness of the tracheo-bronchial air passages in some patients seen by him in El Paso. He has noted, in many cases of asthma, a dry tracheitis, producing "an incessant and spasmodic cough". He has observed aggravation of symptoms in many, upon arrival in the arid climate of El Paso. These symptoms, he says, are troublesome and challenging.

EFFECT OF DESERT CLIMATE

Those of us in the field of nose and throat medicine have noted countless instances where the sick visitor has exhibited a remarkable improvement after a sojourn in the desert areas. The copious, heavy nasal discharges often dry up rapidly and the productive cough lessens in severity. The marked turgescence of the nasal mucosa lessens and nasal ventilation is improved, thereby giving the air-conditioning apparatus of the nose a chance to function. The patient is advised to get out in the open air and sunshine, if only for a few hours daily. If he wishes, horseback riding and golf or tennis are permitted. Tonics are prescribed, including a small glass of wine before meals, with the purpose of helping the appetite. It is not unusual to note excellent gains in weight by many.

After a week or two in the desert most patients seem to have more energy to undertake various activities—the feeling of deadening fatigue begins to disappear. Our office treatments are usually confined to the milder procedures such as displacement and allergy therapy, where indicated. Serial x-ray films on numerous patients demonstrate remarkable clearing of cloudy sinuses, with no definitive therapy whatsoever. It cannot be simple coincidence that so many, each winter, show the same pattern of objective and subjective improvement.

RESUME OF WINTER 1947-1948

During the winter of 1947-'48 the writer cared for 152 patients sent to El Paso from their homes in the mid-west and east. Most came from Illinois, Ohio, Indiana and Pennsylvania. Five were from Toronto, six from Maine, four from Boston, and the rest were from scattered areas in the northeast. Economic status ranged from semi-charity to extremely wealthy. The majority were in moderate to comfortable financial means. The

occupations ranged from railroad depot agent to an owner of a coast-wise steamship line. Many were school children. Most gave histories of repeated, severe respiratory infections, with the usual gamut of complications such as sinusitis, bronchitis, pneumonia, etc. The stay of these patients in El Paso ranged from a few days to the entire winter season. Some were treated two or three times, while others made periodic office visits, throughout the season. Six were operated for nasal polyps, two were operated for naso-antral windows, one had a radical antrotomy. All the rest were treated for their symptoms only, using a displacement in some, anti-allergy therapy in others and a simple nasal shrinkage with general supportive therapy in the rest. Plenty of time was consumed in the administering of applied psychology to many. So often these patients, far from home, are discouraged, fatigued, disillusioned in the quest for health. Confronted by a physician who will take the time to listen to them, understand them, and dispense friendly advice, many begin to show improvement, mentally and physically, very soon after arrival. With many, an effort is made to introduce them into church and club circles so that loneliness may be lessened. All these modes of therapy are of use, to varying degree, in different patients.

No penicillin inhalation therapy was used in any. It is felt that too often this is a waste of the patient's time and money, and it is widely known that many patients are sensitized needlessly to a valuable drug by this procedure. Some patients came to El Paso expecting an overnight miracle. These left soon after their arrival, and were the ones least benefitted. Of the total number of patients seen last winter, over 75 per cent experienced improvment to varying degree, both subjectively and objectively.

SUMMARY

Climate and weather affect all things on this earth, including man. Some human beings are affected adversely and are made ill by weather changes. Many of these are improved in health by a sojourn in desert areas. The El Paso climate is described as suitable for patients having certain diseases of the nose and sinuses. A resume is given of cases treated by the writer during the winter of 1947-'48, with methods and results. Three tables are included.

TABLE ONE

Maximum and Minimum Temperatures
Two Desert Resorts
(Official U. S. Government Figures)

	El Paso		Tucson	
January	58	32	64	34
February	62	37	68	38
March	69	42	74	41
October	77	51	86	51
November	66	39	74	51
December	57	33	65	36

TABLE TWO

Moisture Various Cities

	Av. Yearly Ppt.	Relative Humidity 5 PM-8 PM
Boston	40.14	71
Jacksonville	49.74	74
New Orleans	60.01	71
El Paso	8.86	28
Los Angeles	15.55	60

TABLE THREE

Sunshine Various Localities

	Yearly Per Cent Possible Sunshine	Winter Per Cent Possible Sunshine
Boston	57	40-50
Jacksonville	63	60-70
New Orleans	59	50-60
El Paso	79	70-80
Los Angeles	72	60-70

1. Clemens, S. L., New England Society, 22 December, 1876.
2. Mills, Clarence A., Oxford Medicine 1940, 1:454ff.
3. Petersen, W. F., Arch. Oph. 29:747, May, '43.
4. Egbert, O. E., Reversing Influence of Low Humidity on Intractable Asthma—Paper presented before American Academy Allergy 1947.

The Skin and Its Contents

Anonymous

Unseasonable as it is, we pass along a lay description of the common cold. We have borrowed this little pearl from "The Diary of Samuel Marchbanks" by Robertson Davies, (Clark, Irwin & Company Limited, Toronto), one of the most delightful and refreshing books published since we were very young. We quote . . . "To me the annoying thing about the cold germ is that it has such a poor sense of timing; when I am in perfect health, but would welcome a chance to stay in bed for two or three days, I could not catch a cold if I slept in a freezing locker; but when I am too busy to fuss over trifles I catch colds with the greatest of ease, and have to go on working in spite of them. I know that physicians advise against this, but I have yet to see a physician take a few days in bed because of a cold. They generally keep going as long as they can be carried from patient to patient."

We are somehow unmoved by Mr. Louis Johnson's urgent appeal to drop everything and join the Armed Services. During the recent unpleasantness we had the privilege of serving with an infantry division. During garrison and occupation duty we put in about ten minutes a day signing sick books which left 23 hours and 50 minutes to get drunk or go crazy (we did both). Then we had five months of uninterrupted combat, during which we would have welcomed a little help from the twenty-odd M.O.'s who were bogged down with mapboards, property sheets, command decision, and what not. Matter of cold fact, while almost every General Hospital in the ETO was screaming for EENT men, we had a qualified, certified EENT board man commanding a medical battalion. Pity the late Mr. Ripley passed on at such a tender age.

It's not a very impressive series of cases, but we have had a few patients (fr. L. patiens, —entis, pres. part. pati- —to suffer) who were relieved of their suffering from shingles by a short course of liver extract. We do not feel the relief was entirely psychogenic as they had received everything else in the books first.

We wish our worthy colleagues in other parts of these United States would cease and desist from advising their indigent patients with pulmonary tuberculosis to streak for the Southwest. It merely results in their being sent back home, where at least they are eligible for sanatorium care. We sometimes think a law should be passed prohibiting a known active case of the white plague to cross a state line without written proof that a hospital bed is open and waiting for him at his destination.

We pass along the following without comment. The 80-year-old groom was advised by his physician to take in a boarder during the first months of his marriage to the 20-year-old bride. Some months later the doctor asked how things were going . . . "Fine, just fine; and my wife's expecting a baby soon." "Excellent," said our man, "And how is the boarder?" "Nicely, thank ye, and she's expecting soon too."

INFANTILE ECZEMA

By GEORGE K. ROGERS, M.D., Phoenix, Ariz.

"Infantile eczema" is a term used to cover a skin irritation in children under two years of age. It is characterized by redness, weeping, scaling and thickening of the skin. The eruption may be acute, sub-acute or chronic and may on occasion prove fatal as a result of septicemia, bronchial pneumonia or intestinal intoxication. Modern means of diagnosis now reveal that there are several types of infantile eczema and the importance of making correct diagnoses is of more than scientific interest, for it gives a clue as to the best method of treatment. The various classifications are as follows:

1. **Atopic eczema (neurodermatitis or disseminated neurodermatitis).**

This form is the most common and is usually seen in children with an allergic familial background such as eczema, hay fever, asthma or migraine and this is an important point in arriving at the correct diagnosis. The stronger the allergic background the earlier the disease makes itself manifest in the child, and the more difficult it is to obtain a response to treatment. The etiology is an allergen to which the infant has become sensitized after previous exposure, and it may be of internal or external source. Allergens of internal source are the most likely in infants under six months of age and the most common of these are milk, egg and wheat. As the child grows older the possibilities of coming into contact with external factors widen, thus we find allergens of external source becoming increasingly important and the most important of these are wool, feathers and silk. The eruption has certain distinguishing features not so much in appearance as in distribution. The face, nape of the neck, cubital and popliteal fossae are usually the first sites affected. It is noteworthy that the eruption leaves a circumoral area of normal skin. The eye-brows and scalp are frequently spared; and involvement, if it occurs, appears later. The eruption can become generalized, and as it subsides, the first places to break out are usually the last places to respond to treatment.

2. **Seborrhoeic eczema (seborrhoeic dermatitis).**

This is probably the second most important type of infantile eczema. The etiology of seborrhoeic dermatitis is unknown but it is likely that metabolic factors and diet play a more important role in the disturbance of the sebaceous glands than do fungi or bacteria. The eruption is characterized by appearing first on the scalp as a yellowish greasy type of scale, then spreading to other areas of the body. The skin under the scales then turns red and becomes weeping in character. The face, the eye-brows and upper and lower lips are usually involved, thereby distinguishing it from the atopic variety.

3. **Contact dermatitis (Dermatitis venenata, intertrigo).**

This eruption, while occurring anywhere on the body, is usually found where moisture, warmth and friction results in irritation, such as the folds of the neck, under the arms and between the legs. The buttock, the site of napkin dermatitis, is a result of infrequent changing and improper cleansing of the diapers. Here the eruption is usually acute and is characterized by redness and the formation of papulo-vesicles. One must distinguish this variety from syphilis.

4. **Infectious dermatoid dermatitis.**

This is secondary to an antecedent discharge or exudate such as running nose or ear, abscess, or scratching and irritation as a result of lice infection, a seborrhoeic or an atopic dermatitis. The eczema starts about the region of the infection and may remain circumscribed or, the skin becoming sensitized, it can rapidly spread so as to involve the entire body. It is an acute variety and is usually weeping in nature.

5. **Eczema as a result of microorganisms.**

From bacterial or fungus foci generalized eczematous eruptions may develop. These eruptions can be due to an extension of the original focus anywhere in the body or to an allergic response of the individual to the offending organism in which case they are known as bacterids, in the case of bacterial infections, or dematophytids, in the case of fungus infection. The one most frequently seen is that due to monilia (thrush), and may result in a generalized moniliasis, not only of the skin but of other organs, and can result in death.

6. **Nummular eczema (orbicular eczema).**

It gets its name from the characteristic well circumscribed red annular or oval patches surmounted by papules or papulo-vesicles and situated principally on the extremities, usually the dorsal aspects. While the cause of this type of eczema is unknown, it is probably a form of the atopic variety. It is noted for its remissions and exacerbations as well as its resistance to all forms of therapy.

7. **Combinations.**

Needless to say, combinations of any of the above can occur. While it is easy to diagnose the classical type, nevertheless, some cases baffle the most experienced dermatologist.

THERAPY

A. **General considerations.**

Under this heading one must take into consideration the parents as well as the child. It is best to inform the parents that the child's eruption is not contagious, that it will probably have exacerbations and remissions and barring secondary infection the skin will clear up, even in severe cases, without leaving a blemish. Flareups occur in lessening numbers as the children grow older. After puberty only a few of the more persistent cases will have recurrences. The infants are usually healthy in every other respect and by way of consoling the parents one might mention that the allergic type of child is usually the smart one in school.

B. **Diet.**

It is the fortunate physician who can eliminate one or more items from the infant's diet and thereby produce beneficial results. It is my experience that changing the child's diet is of little benefit and upsets both the child and the parent. Milk, egg and wheat are usually the offending allergens and good results are sometimes obtained by eliminating one or more of these. Unfortunately, however, sensitization to more than one food is common. Boiling the milk for three to five minutes or changing to mothers', cows', goats' or canned milk may prove helpful. Soybean oils are on the market and may be substituted in place of milk, always bearing in mind the possibility of a kidney or gastro-intestinal disturbance. The use of specific Propeptans taken forty-five minutes before the meal is extremely useful when the offending food allergen can be found. The incidence of eczema is lowest in breast fed babies; and so these babies should not be weaned, but one should ascertain what food the mother is eating and whether she is taking any medicine. Fish oils, or orange juice should be replaced with crystalline vitamines. Frequently the eczematous process is favorably influenced if fat babies are underfed or poorly nourished babies built up. Fortunately, most infants with food sensitivity out-grow this condition. An

attempt at desensitization or transforming an allergic child into a non-allergic child is futile so the majority of children obtain their best relief from local treatment.

C. **Skin Testing.**

In infants, I feel, skin testing is of doubtful value and this applies to foods as well as inhalants and contacts. The infant's skin does not respond to tests as does that of an adult; hence they are unreliable. One will find a child that gives a positive skin test to milk but can tolerate milk without a clinical flareup; and, again, a child showing a negative reaction can, on drinking milk, have exacerbations. Sensitivity to house dust and human dandruff must be suspected in the most resistant allergic cases.

D. **Specific therapy.**

Countless numbers of internal and external prescriptions are suggested in the treatment of these cases. Only a very few of the ones that have been found most satisfactory will be mentioned in this paper.

1. **Internal.**

Of the various internal remedies the only ones I will mention are those used in the atopic or nummular variety of eczema. The anti-histamine drugs now on the market are being used by most practitioners, and most cases of infantile eczemas have had a thorough tryout with them before reaching the dermatologist. Perhaps this is one reason why my results with these drugs have not been as encouraging as some physicians. Nevertheless, they are well worth a trial. The solutions such as elixir of benadryl or pyribenzamine are given in drams one-fourth to drams one-half doses three times a day, taken after meals. In cases of infectious eczematoid dermatitis and bacterial infections the internal use of sulfa drugs or penicillin is indicated in conjunction with external therapy. Sedation is seldom necessary and if so elixir alurate minims 10 to 20 or elixir of phenobarbital minims 5 to 15 in water may be used when needed.

2. **External.**

By all odds the most satisfactory results in treating infantile eczema are achieved by proper local care of the skin.

A most important consideration is the prevention of scratching. It is a well known fact that a night of scratching will undo a week of treatment, hence if the child's parents fail to cooperate it is necessary to hospitalize the patient. Methods used to prevent scratching are many. Tongue depressors or cardboard tubes slipped over the arm will prevent the infant from bending the elbow and getting at the irritated area. Mittens, masks, improvised strait jackets and pajamas with hands and feet which can be pinned to the mattress are other means of protection. One must also instruct the parents that they must not attempt to cleanse the skin before applying fresh medication as this merely results in more irritation.

The second important rule to follow in the external management of the skin is to treat the eczematous process rather than any specific condition or underlying cause. In the acute stage where there is weeping one may use:

1. **Wet compresses, or**
2. **A paste.**

Compresses consist of Burow's solution, made by adding 1 teaspoonful of aluminum acetate power to 1 pint of water or 2 per cent boric acid solution. They should not be allowed to dry; and by covering with cellophane or wax paper rapid evaporation can be prevented as well as wetting of the bed linen. They should be used until the acute phase has passed.

Of the various pastes, a tar paste is preferable. Salves are contra-indicated as they do not absorb moisture; and the serum oozing from the skin merely pushes up the salve, and so increases the irritation, while paste absorbs the moisture; and the medication is thus kept in direct contact with the skin. One of the best of these pastes is crude coal tar 5 per cent in Lassar's paste; another is Naftalan 10 per cent in Lassar's paste. This is best smeared directly to a strip of cotton material or mask and then applied to the skin. It is applied thickly and left in place 24 hours; at that time it is removed. Without attempting to cleanse the skin, fresh paste is then applied. This is continued until the process enters the sub-acute stage. The scalp is the only place where soap and water can be safely used, and here it may be utilized to remove crusts before the application of medication. Another method is to saturate a piece of cotton material with olive oil and place on the scalp for several hours, then wash the scalp, taking care to prevent the soap and water from coming in contact with the other areas. A salve such as sulphur precipitate 3 per cent in Neobase (Burroughs, Wellcome & Co.) rather than a paste, is applied at least twice a day and the scalp shampooed every other day. In cases or infectious eczematoid dermatitis, disregard the original lesion and treat as above until the irritation subsides and then treat the primary focus. If it is due to fungi, 2 per cent aqueous solution of gentian violet should be painted on once or twice a day, then dusted with talcum powder. In eczematous bacterial eruptions and in cases of secondary infection, penicillin ointment consisting of:

Penicillin, 30,000 units,
Neobase qs to oz. 1,

should be applied every three to four hours without covering these areas. In cases of napkin dermatitis it is important to instruct the mother to wash the diapers with soap and water, thoroughly rinse and then dip them in a solution of boric acid, using two teaspoons boric acid powder to the pint of water. Rubber panties are not to be worn.

In the sub-acute stage general cleansing once or twice a day with olive oil (or any vegetable oil in preference to mineral oil) or starch solution (using one cup of linit starch to the basin of warm water) is helpful and then a mildly stimulating lotion is applied several times a day without covering the parts. Such a lotion is as follows:

Phenol minims 30,
Liquor carbonis detergens drams 3,
Zinc oxide oz 2,
Glycerine drams 4,
Lime water oz. 1,
Rose water qs ad oz 8

If this proves too drying, the addition of olive oil to make an emulsion will prove beneficial. In cases which fail to respond after a period of five to six days change to Naftalan 3 per cent in Lassar's paste applied once daily and the parts covered with a piece of cotton cloth. In the seborrhoeic variety of eczema 3 per cent sulphur precipitate may be added to this lotion with or without the tar. In contact dermatitis the tar and sulphur both may be eliminated from the prescription and the lotion applied several times a day.

In the chronic stage a paste as mentioned above or salve such as:

Liquor carbonis detergens 5 per cent,
Lanolin,
Petrolatum,

should be applied twice a day. In the chronic seborrhoeic type sulfur precipitate 3 per cent may be substituted for the tar or the sulfur and tar may be used together. It is best, if the lesion is particularly chronic, to cover the medication with a piece of gauze or cotton material.

In all these cases, except for the scalp, soap and water is to be avoided; for, while this does not primarily cause the eczema, nevertheless it can be a great source of irritation. Similarly, wool and feathers, which can be a

(Continued on Page 228)

Reconstruction Of The Hand With Respect To Tendon Injuries*

By Dr. Robert Cochran, Fort Worth, Texas

It has been justly said, "It is more important to save the hand of a young workman than to operate for an extensive cancer in an old man." The successful surgery of traumatic wounds, especially of the hand, is far more exacting of judgment, skill and time than is elective surgery. However, the paradoxical disinterest of man in his hands must still remain a great mystery. It is a common observation that any person with an injured hand, because of the apparent emergency, will accept the services of anyone from the corner druggist with his mercurochrome and iodine to the neighboring physician.

The restoration of function to a hand seriously incapacitated by neglect calls for prolonged physical therapy, tension splinting, many stage operative procedures, patience and faith, to obtain improvement. In few fields of surgery do minor disturbances of wound healing interfere so seriously with the end results as in tendon repair. It is still an every day occurrence for this complex piece of surgery to be attempted in the emergency room or in a doctor's office. (1)

SURGICAL TREATMENT

It is not the purpose of this paper to deal with primary tendon repair, but rather to consider the surgical treatment of the severed tendons after the primary repair has yielded poor results.

No other field of surgery was given greater impetus in World War II than that of surgery of the hand. In this conflict there were over 15,000 injured hands, the majority of which eventually landed at one of the Hand Centers. In these centers, under the expert guidance of Dr. Bunnell, many hopelessly useless hands were restored to good functioning hands. Out of this there has been formed the American Society for Surgery of the Hand, and in this group we are interested in treating afflictions of the hand, and its reconstruction toward maximum usefulness following injury.

In reconstructing the injured hand certain definite principles must constantly be borne in mind, and these must be strictly adhered to if a desirable result is to be attained.

The first of these is to allow sufficient time to elapse from the date of healing before attempting reconstruction. This varies from two to four months, except where direct suture of the tendons is to be done. This must be accomplished not later than two months.

The second is to excise the cicatrix and replace with adequate skin coverage. This may be done by:

(a) Tubular pedicle graft.
(b) Direct pedicle flap.
(c) Free full thickness graft.
(d) Split thickness graft.

TYPE OF GRAFT

The type of graft to be used depends upon the extent of the skin loss, and also the structures to be covered.

After good skin has been supplied to the affected part, any bone carpentry that is necessary should next be done to insure a good bony framework. When this has been accomplished tendon and nerve repair can be done. In the lacerated finger in which both the volar digital nerves and tendons have been severed it is necessary to do a nerve repair, before attempting any repair of the tendons. I have seen numerous instances of this particular injury, in which both these structures have been severed, and no attempt whatever has been made to repair the nerves. It is the prevalent feeling, apparently, that the main thing to accomplish is to get the ends of the tendons sutured, regardless of how much damage is done to the hand. The end result is a finger, in which the skin is smooth and glistening, has no sensation, is atrophic and has no motion.

*—Read before the Meeting of the Texas Railway & Traumatic Surgical Association, San Antonio, Texas.

SECONDARY REPAIR

Secondary repair of tendons may be done by one or a combination of the following:

(1) Tenolysis with insertion of paratenon.
(2) Direct suture.
(3) Tendon graft.
(4) Tendon transfers.

Tenolysis may sometimes be done with good results by merely freeing and removing the cicatricial tissue, and interposing paratenon between the tendon and the bone, thus creating a gliding surface for the tendon. The paratenon is best obtained from the triceps muscle one and one half inches above the elbow, or from the outer surface of the deep fascia and fascia lata over the lower two thirds of the thigh.

Direct suture may be done in the palm, the wrist, the distal segment of the fingers, in the thumb, and, of course, all the extensor tendons, providing there has not been too great a length of tendon incorporated in the cicatricial tissue. As stated before, this method of repair must be done within two months of the injury. Direct suture, secondarily, in the proximal segment of the finger, and extreme distal portion of the palm is very unsatisfactory, and yields poor results. In these instances, it is almost always necessary to resort to tendon graft.

FREE GRAFTING

In the majority of cases of secondary tendon repair it is usually necessary to resort to free grafting instead of to direct suture, because it is rarely possible to draw the two parted ends together for suture without doing so under great tension. After a tendon has been nonfunctioning for many months, the degeneration of disease sets in and renders it unfit for repair. This applies especially to the distal end of a tendon and the curled up proximal end, but not to a tendon which has reattached and been under intermittent tension. Where a tendon is found to be rough and adherent, it is best to excise it completely and substitute in its place a free tendon graft. In placing the tendon graft, the pullout stainless steel wire suture of Bunnell, using No. 34 stainless steel wire, yields the best results in that no foreign body remains in the tendon. (2)

There are several sources of tendon grafts which may be enumerated as follows:

(1) Palmaris longus.
(2) Flexor digitorus sublimus.
(3) One or two long extensors can be taken from the dorsum of the hand.
(4) Long extensor tendons of the toes except that of the great toe.
(5) Strips of fascia lata or the triceps tendon.

TENDON TRANSFERS

In some instances of extensive hand injuries, tendon transfers are necessary. When such is necessary the following principles are essential:

(1) Correct the deformity. This cannot be accomplished by merely transferring tendon, but we must reshape bones and joints by osteotomies, capsulotomies, muscle stripping and correct contractures.

(2) The muscle of the transferred tendon must be red, healthy and adequate in size to carry on the muscle balance and the new motion desired.

(3) The transferred tendon should be placed in a bed through which it can glide, otherwise it will adhere.

(4) The transferred tendon should, when possible, pull in a straight line, and where a pulley is used the muscle should be sufficiently strong to compensate for the friction.

(5) The amplitude of motion of the transferred tendon should be sufficient to execute the motion desired. We should avoid attaching the transferred tendon to two tendons of different amplitudes of motion. (2)

CONCLUSION

Statistics of industrial acidents show that injuries and infections of the hand cause more loss of working time during the individual's productive years than any other single condition.

Surgery of the hand is still the most neglected field in surgery, and many, many hand injuries are still treated in hospital emergency rooms and doctors' offices. The old axiom still holds that: "The fate of the injured hand rests with the first doctor who treats it."

However, experiences gained at the Hand Centers during the last war have proved without doubt that many hopelessly injured hands can be restored to useful hands by proper reconstructive procedures, combining basic surgical fundamentals with plastic, orthopedic and neurologic surgery.

In few fields of surgery do minor disturbances of wound healing interfere so seriously with the end results as in tendon repair. Many times, even with scrupulous asepsis and atraumatic technique, adhesions will form, and cause a limitation of the motion of the affected digit. However, when such occurs, before evaluating disability, a further attempt should be made to restore function by one, or a combination of the methods described, namely:

(1) Tenolysis (3) Tendon graft
(2) Direct suture (4) Tendon transfers

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EL PASO TUMOR CLINIC

CASE NO. 370

Dr. Eidenoff—This patient, a white female, age 53, was referred to me because of history suggesting possible pelvic malignancy. Her story is that she first experienced pain in the lower abdomen about five months ago, which has grown progressively worse. In addition she noted a progressive weakness and loss of appetite. She gave no history of significant vaginal bleeding. When I examined her there were multiple hard tumors on the surface of the uterus. The cervix was red, hard and infiltrated and bled slightly to touch.

Dr. Boehler—The corpus is enlarged with some suggestion of invasion to the left side. The cervix is twice normal size with thickening and fullness extending into the right fornix. Rectal examination revealed the right side fixed, not frozen, but half of the wall fixed. Speculum examination showed a small amount of bleeding granulation tissue on the posterior lip. This is probably an endophytic type of cancer and could be easily missed. This also helps to explain the symptoms of pain, etcetera, with minimal bleeding. Biopsy would be necessary to rule out the possibility of syphilitic lesion. My impression is carcinoma of the cervix, stage three, League of Nations classification. We would like, in view of the invasion of the right side of the pelvic wall, to re-examine the patient in ten days after treatments are started. Much of this fullness may be due to infection.

Dr. Hart—A gross biopsy of the cervix was made and the specimen consisted of a dull, grayish red, granular fragment of tissue measuring 12 mm. in diameter. Microscopic examination shows irregular columns and strands of neoplastic cells supported by a delicate compact stroma. The tumor cells are growing in syncytium and show a slight tendency to whorl arrangement. Mitoses are relatively infrequent. The diagnosis is squamous cell carcinoma, Grade 2.

Dr. Fuchlow—Films of the chest show no pathology. Intravenous urogram reveals pyelectasis, Grade 2, right side and Grade 4 on the left side. The obstruction appears to be in the distal third of both ureters, probably due to the invasion of the malignancy. The blood picture is as follows: RBC—4,280,000; WBC—10,400; Hgb. —79 per cent; sedimentation rate—60 mm. in one hour. Papinicolaou stain reveals numerous malignant cells.

Dr. Prieto—I notice it is routine procedure to do intravenous urograms on all cases of carcinoma of the cervix. Here is one that you state has positive evidence of obstruction. Could Dr. Boehler or Dr. Gibson tell us if they would advise any form of specific treatment?

Dr. Boehler—We do not advise any specific treatment. We assume that in this case it is due to the invasion of the carcinoma, and any manipulation would be detrimental to our general problem in dissemination of the carcinoma. I think Dr. Fuchlow would agree that most of these cases, seen in this stage will be corrected by the preliminary external radiation. In fact, that is another of the reasons we prefer external radiation to precede any radium or intravaginal therapy.

Dr. Gibson—I quite agree that this is no time to attempt dilatation. In cases where the obstruction occurs some months after the treatments have been completed dilatation can be used for palliation only. We are not at all sure whether the obstruction is due to scarification or malignancy, but in either case when symptoms obtain we are justified in dilating these ureters and with the aid of chemotherapy and antibiotics control the infection. Dr. Fuchlow, is it your feeling that this obstruction is due to radiation therapy in cases some time after the radiation therapy is completed?

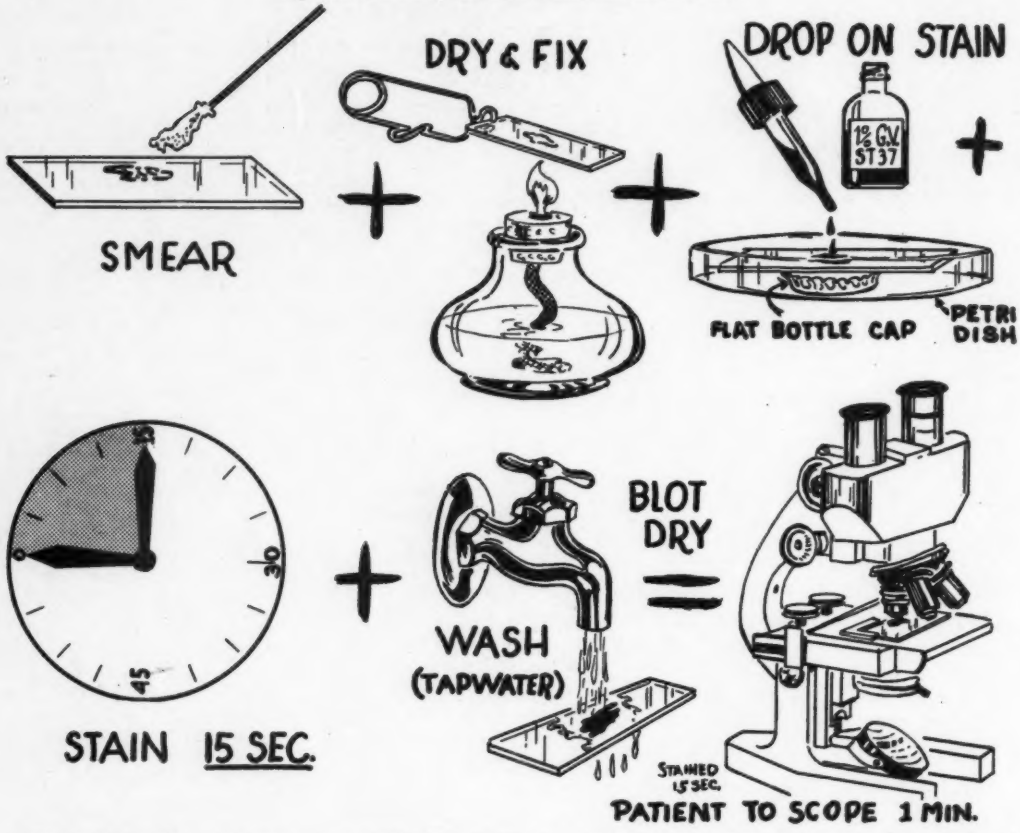
Dr. Fuchlow—Since it has been pretty well established that the obstruction usually occurs at the same level, at or near the pelvic brim, it is unlikely that the obstruction is due to damage to the ureters themselves. Whether it is due to the malignancy or radiation fibrosis is hard to determine. Either and both have been demonstrated at necropsies. At any rate, we feel that the cause of the obstruction is usually extrinsic.

Dr. Boehler—We have here a clinical Stage Three, Grade Two, squamous cell carcinoma of the cervix, the management of which is entirely radiological.

Dr. Fuchlow—The policy adopted by the clinic in this group of cases is external radiation to the pelvis to tolerance, to be followed by intravaginal cone therapy and/or radium. Here is a lesion arising in the endocervix, at least at the junction of the cervical os and evidently with extensive intra-uterine extension. Our procedure has been in Stage Three cases to use radium with intra-uterine applicators and colpostats. However, this decision would best be made at the completion of the external radiation series. At that time an examination by both the radiologist and gynecologist should reveal some, if not complete, restoration of the normal anatomy of the vaginal vault, which would help to determine which would be the best procedure.

Fifteen Second All-Purpose Stain For Office Use

By R. D. Haire, Jr., M.D, Roswell New Mexico



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This method was first brought out by the writer as a stain for treponema pallida and published in the Journal of Laboratory and Clinical Medicine, August, 1938. Now eleven years, many thousand slides, and fifteen seconds later its real value is in the simplicity of the technic, clarity of the field, and rapid staining in routine office work.

Gentian violet 1 per cent may be made by placing one gram of powdered stain in a mortar and while mixing add 100 cc. of S.T. 37 Antiseptic Solution slowly. Usually no filtering is needed; however, if made from commercial gentian violet by your druggist, you may find various sized round purple granules, requiring filtering through one layer of paper.

Armentarium and method of staining is self explanatory in the illustrations above.

Conclusion: 1 per cent gentian violet in S.T. 37 Antiseptic Solution makes a valuable, clear cut stain revealing everything on the slide in clear detail, requiring only fifteen seconds of staining, less than one minute from patient to microscope, and needs no special equipment or trained personnel.

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INFANTILE ECZEMA

(Continued from Page 225)

source of irritation as well as an etiological factor, should be kept from direct contact with the child.

X-ray should not be used in these young children, but ultra-violet radiation is sometimes beneficial and should be tried in the more persistent cases.

Finally, when the condition is well under control, one should instruct the parents to use starch and water (Two cups Linit starch to the one-half tub of water) for cleansing for some weeks and then gradually start using a lanolin type of soap such as Basis soap (Duke Laboratories) or Almay cold cream soap.

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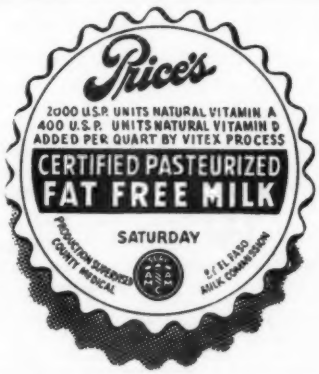

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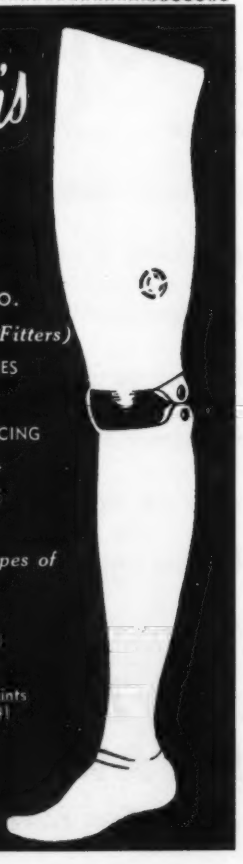

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